FINGER LAKES HOSPITAL EXPERIMENTAL PAYMENT PROGRAM TITLE XIX (MEDICAID) STATE PLAN AMENDMENT

BACKGROUND

The Finger Lakes Hospital Experimental Payment Program (FLHEP) was implemented as of January 1, 1981 as a Medicare and Medicaid demonstration system under the authority of sections 402 and/or 222 of the Social Security Amendments of 1967 and 1972, respectively. This program continued until December, 1986. From January 1, 1987 to December 31, 1994, the Finger Lakes Area Hospitals' Corporation (FLAHC) had received approval from the Federal Health Care Financing Administration (HCFA) for a waiver of Medicare reimbursement principles, to permit the continuation of the Finger Lakes Hospital Experimental Payment Program system under the authority of section 1886(c) of the Social Security Act, as amended. Section 1886(c) requires that the State hospital reimbursement control system for which a Medicare waiver is granted also apply to Medicaid revenues and expenses. Hence, in 1987, FLHEP was continued as a cost control system under section 1886(c) (known as FLHEP-2) rather than as a demonstration system. FLHEP was also continued for the 1988-1990 periods as FLHEP-3, and for the 1991-1993 periods (as FLHEP-4). FLHEP will continue as a cost control system under section 1886(c) for the period January 1, 1994 through June 30, 1996 as FLHEP-4E and for the period July 1, 1996 through December 31, 1996 as FLHEP-4EE. For 1995 and 1996, FLAHC member hospitals will no longer be covered under a waiver of section 1886(c) of the Social Security act. Beginning in 1995 member hospitals will be reimbursed for Medicare patients in the same manner as other hospitals in New York State. Medicaid and Blue Cross continue to be participating payers in the FLHEP system. The hospitals participating in this program are F. F. Thompson, Geneva General, Myers Community, Newark-Wayne Community, and Soldiers and Sailors.

SYSTEM OVERVIEW

For the period January 1, 1996 through December 31, 1996, all FLHEP hospitals will continue to participate in a total revenue system, with the revenue allocated among Medicare and non-Medicare payers using standard Medicare apportionment techniques. Inpatient reimbursement for all major third-party payers (Medicaid, Blue Cross) will be through a DRG-based case payment methodology similar to the case payment methodology followed by New York State for its non-Medicare inpatients. The case payment rates for the participating hospitals will be based on their historical payment base (1987 costs trended forward and adjusted). The design of FLHEP-4E and FLHEP-4EE includes continuation of the demonstration for the use of a severity measure that was started under the FLHEP-3 contract. Medicaid funds will be used to fund inpatient services only. The severity study will be funded from a statewide pool in which there is no federal financial participation.

This plan covers the third year extension of the FLHEP-4 contract which runs through December 31, 1996. Extending this Agreement will continue all existing FLHEP programs while providing the Finger Lakes Corporation sufficient time to transition to a modified reimbursement system.

The FLHEP-4E and 4 contracts, like the previous FLHEP contracts, are based on the concept of regional cooperation in the planning and delivery of services in the most cost effective manner possible. To that end, the participating hospitals shall engage in cooperative community service planning to ensure that changes in services or facilities continue to conform to this concept of cost effective delivery and organization of care in the area.

To calculate the rates, FLHEP-2 1987 hospital costs are aggregated and allocated to each member hospital using the following percentages:

FF Thompson Hospital	22.8119%
Geneva General Hospital	32.1315%
Myers Community Hospital	11.1376%
Newark-Wayne Community Hospital	24.4871%
Soldiers and Sailors Memorial Hospital	9.4318%

This cost, also known as the gross aggregate dollar amount, is the basis for the FLHEP-4E and 4EE rate calculations. The following amounts are subtracted from each hospital's gross aggregate dollar amount: The cost of actual 1987 capital, physician coverage, and the amount included for medical education. The 1987 reimbursable operating costs are increased by a factor of .5% to provide funding for advances in medical technology, and by the 1987 through 1996 trend factor to reflect inflation, and then apportioned to inpatient and outpatient services, acute units, Medicare, and non-Medicare, using 1987 FLHEP-2 final settlement data.

The trend factors are calculated, using the Panel of Health Economists' methodology, for various groups of hospitals depending on their geographic location (upstate, downstate), urban or rural setting, and size (as measured by the number of patient days during a calendar year). This methodology is detailed in section 86-1.58 of attachment 4.19-A, Part I of the Plan. The FLHEP hospitals fall into three categories:

1. Upstate urban, less than 30,000 patient days
2. Upstate urban, greater than 30,000 patient days
3. Upstate rural, less than 15,000 patient days

The values of the trend factors for 1996 for these three categories are provided below:

Category	1996 (Initial)
1	2.80
2	2.81
3	2.80

The initial trend factors are calculated using the latest data available; these values are subject to change as more current data become available. Consequently, the interim trend factors are adjusted up or down and these revised trend factors are then used to make prospective payment rate adjustments.

The inpatient acute, non-exempt, non-Medicare portion of each hospital's 1996 reimbursable operating costs are converted to an inpatient case payment rate for each hospital which is uniform for all of the non-Medicare payers. Each hospital's 1996 hospital specific case payment rate is blended with a group rate calculated in accordance with the State specified methodology, as detailed in section 86-1.53 of Attachment 4.19A, Part I of the Plan except that rural hospitals have the option of choosing a rate which is entirely the hospital specific rate. Each hospital's blended 1996 case payment rate will consist of two components. Forty five percent of the rate will be the hospital specific case payment rate and the remaining 55% will be the group average case payment rate. Hospitals will be grouped under the methodology described in section 86-1.54 of attachment 4.19A, Part I of the Plan.

Each hospital also receives an add-on for pass-through costs which reflect (1) the hospital's actual cost for capital; (2) the 1979 physician coverage costs trended forward in accordance with section 86-1.58 of attachment 4.19A, Part I of the Plan and adjusted for changes in physician billing practice; and (3) the amount included in the regional aggregate dollar amount in 1987 for Medical Education trended in accordance with section 86-1.58 of attachment 4.19A, Part I of the Plan.

Each hospital is paid for each inpatient discharge, which is not an outlier or exempt as defined below, on or after January 1, 1996 the hospital's blended non-Medicare case payment rate, adjusted by the Service Intensity Weight related to the discharge, plus the medical education, the physician coverage and the capital add ons.

The hospitals shall be paid for Exempt Unit services by the payers on the same methodology and cost base as such units are paid in other hospitals in New York State. This methodology is detailed in section 86-1.57 of Attachment 4.19-A, Part I of the Plan.

Alternate Level of Care ("ALC") reimbursement is paid according to the New York State reimbursement methodology described in section 86-1.56 of Attachment 4.19-A, Part I of the Plan. The rate will be paid at the regional average nursing home per diem rate.

Hospitals transferring patients are paid a per diem rate which is calculated under the methodology detailed in section 86-1.54 of attachment 4.19-A, Part I of the Plan.

Outliers shall be paid in accordance to section 86-1.55 of Attachment 4.19-A, Part I of the Plan.

Future funding of expansion of services or facilities which require State Certificate of Need (CON) approval will occur through an adjustment determined according to State procedure and consistent with methodology described in section 86-1.61 of Attachment 4.19-A, Part I to the adjusted gross aggregate dollar amount for incremental non-volume related operating costs and adjustment to the capital add-ons when such projects are approved and implemented.

The payers participating in the contract have agreed to pay, on final settlement, their respective shares of the amount, if any, needed to assure that the hospitals receive their actual capital, and trended 1987 medical education costs and physician coverage costs.

The Health Department will certify the rates under the FLHEP-4E and 4EE Agreement for Medicaid as the rates for each hospital, contingent upon approval by HCFA of the Title XIX State Plan Amendment providing for reimbursement pursuant to this methodology.

The participating hospitals will each contribute to an administration and research fund which will be used for administrative costs of the program, data base development, to support programs designed to increase efficiency, and the severity study. The data base will include sufficient data to assign a severity measure to each case, and will allow for a statistical analysis of the changes in severity that occur, and how severity varies across hospitals and over time.

Each hospital is required to purchase or provide through a state pool excess physician malpractice insurance pursuant to New York Law. There is no federal financial participation for these malpractice costs.

For each year of the FLHEP-4E and 4EE contract the case payment rates are adjusted to include changes to the hospitals' adjusted gross aggregate dollar amounts for capital and non-volume related costs of approved CON projects and to reflect inflation by means of a trend factor adjustment. The per diems are similarly adjusted. Capital, medical education and physician coverage cost add-ons are adjusted to reflect actual and trended 1987 costs and payments, respectively.

Adjusting the Case Mix Penalty for Severity Increase

The purpose of this material is to describe the method of calculating the increase in severity of illness using the SysteMetrics Staging Measure, and then applying that increase as an offset against the creep component of the case mix penalty which is detailed in section 86-1.61 and 86-1.75 of Attachment 4.19A, Part I of the Plan. This offset began to be applied within the FLHEP-3 contract starting in 1989. The base year for the measurementof severity is 1987, the same base year as was used for the rate calculations in the FLHEP-3 contract.

The Finger Lakes area hospitals are currently being paid on the basis of the DRG assigned to each patient. The disease staging (Q scale) software program produces two outputs on severity; one written DRG and another relating to overall severity. The severity measure will be used as on offset to the case mix penalty which is applied if the criteria stipulated in section 86-1.75 of attachment 4.19A, Part I of the Plan are met.

The offset shall only be applied if the severity increase is positive, and the offsetshall not exceed the amount of the creep component of the case mix penalty calculated by OHSM, i.e., the offset shall not turn the creep component of the case mix penalty to a positive adjustment.

Calculation of the Severity Increase

The change in severity is calculated for each FLAHC hospital from 1987 to the rate year (1989 and subsequent years). The methodology used to calculate this severity increase is described in the following paragraph.

Calculate the average aggregate severity of all the non-Medicare cases in the base year and in the rate year, T(b) and T(r) respectively. Calculate the average DRG weight for these cases, W(b) and W(r). The average severity in the base year is then T(b)/W(b)=S(b) and the average severity in the rate year is T(r)/W(r)=S(r). Then the percentage increase in severity is

$$100 \times (S(r)/S(b) - 1).$$

If this increase in severity is positive, then it shall be used as an offset to the creep component of the case mix penalty to be applied for the year. If the creep component of the case mix penalty calculated by OHSM is P (as a percentage), and the percentage increase in severity is Q, then the case mix penalty shall be reduced to P - Q, but not to less than zero.

An example of the severity offsets calculation is illustrated in Attachment A. This reduction shall be applied to the case mix penalty for 1989 and for subsequent years of the FLHEP.

Amendment providing for reimbursement pursuant to this methodology.

The participating hospitals will each contribute to an administration and research fund which will be used for administrative costs of the program, data base development, to support programs designed to increase efficiency, and the severity study. The data base will include sufficient data to assign a severity measure to each case, and will allow for a statistical analysis of the changes in severity that occur, and how severity varies across hospitals and over time.

For each year of the FLHEP-4 contract after 1991, the case payment rates are adjusted to include changes to the hospitals' adjusted gross aggregate dollar amounts for capital and non-volume related costs of approved CON projects and to reflect inflation by means of a trend factor adjustment. The per diems are similarly adjusted. Capital, medical education and physician coverage cost add-ons are adjusted to reflect actual and trended 1987 costs and payments, respectively.

The term of the FLHEP-4 Agreement is January 1, 1991 through December 31, 1993. The term of the FLHEP-4E Agreement will be January 1 through December 31, 1994.

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Severity Adjustment Measurement System

The Medicare program, New York State and other states and payors, have been using the Diagnosis Related Groups (DRGs) for payment purposes. While the DRGs are reasonably homogeneous in regard to resource use, they are far from ideal, and they may not take adequate account of the severity of illness of patients. A number of adjustments have been included in payment systems to partly remedy this problem. For example, the indirect medical education adjustment in the Medicare Prospective Payment System, and the disproportionate share adjustment, are added to partly to deal with this problem. A better way to deal with the problem may be to measure severity of illness within the DRG and adjust for it directly. The purpose of the severity study that is being undertaken by FLAHC is to incorporate a severity measure to obtain a better understanding of the operation of the health care system, e.g., are patients who are travelling to obtain services in urban hospitals doing so because they are more severely ill, or for some other reason?

This study will be funded through hospital payments made to a Statewide Pool for which there is no federal financial participation. Medicaid moneys will be used to pay for inpatient hospital services.

The purpose of this demonstration is to develop a payment

system which incorporates a measure of the severity of illness of the patient into the determination of the appropriate payment rate, to show that it is feasible to implement such a system in a group of rural hospitals, and to carry out some research on the variation in severity over time, across payor classes, across hospitals, and between cases treated in the area and cases treated outside of the area.

After considerable discussion, review of the literature, and presentations from several of the severity system vendors, Disease Staging (Q-scale), which is distributed by SysteMetrics, was chosen to support the development of the severity adjustment payment system. The FLAHC hospitals are currently being paid on the basis of the DRG assigned to each patient. The Disease Staging software program produces two outputs on severity level--one within the DRG and one overall--which could be useful in refining the DRGs in a payment demonstration. After discussions with the Office of Health Systems Management, it was decided that the severity measure would not be used to adjust payment rates directly, but would be used as an offset to the case mix limit that is applied if the case mix of the hospital and the State as a whole increase above certain thresholds. The case mix limit for 1989 and subsequent years is to be offset by an increase in case mix severity within the hospitals participating in the demonstration.

Adjusting the Case Mix Penalty for Severity Increase

The purpose of this material is to describe the method of calculating the increase in severity of illness using the SysteMetrics Staging Measure, and then applying that increase as an offset against the creep component of the case mix penalty applied under the FLHEP contract. This offset began to be applied within the FLHEP-3 contract starting in 1989. The base year for the measurement of severity is 1987, the same base year as was used for the rate calculations in the FLHEP-3 contract.

The offset shall only be applied if the severity increase is positive, and the offset shall not exceed the amount of the creep component of the case mix penalty calculated by OHSM, i.e., the offset shall not turn the creep component of the case mix penalty to a positive adjustment.

Calculation of the Severity Increase

The change in severity is calculated for each FLAHC hospital from 1987 to the rate year (1989 and subsequent years). There are two ways in which the increase in severity can be calculated:

1. Calculate the average within DRG severity for the base year (1987) and for the rate year (1989 or a subsequent year). This is the weighted average severity per case, with the